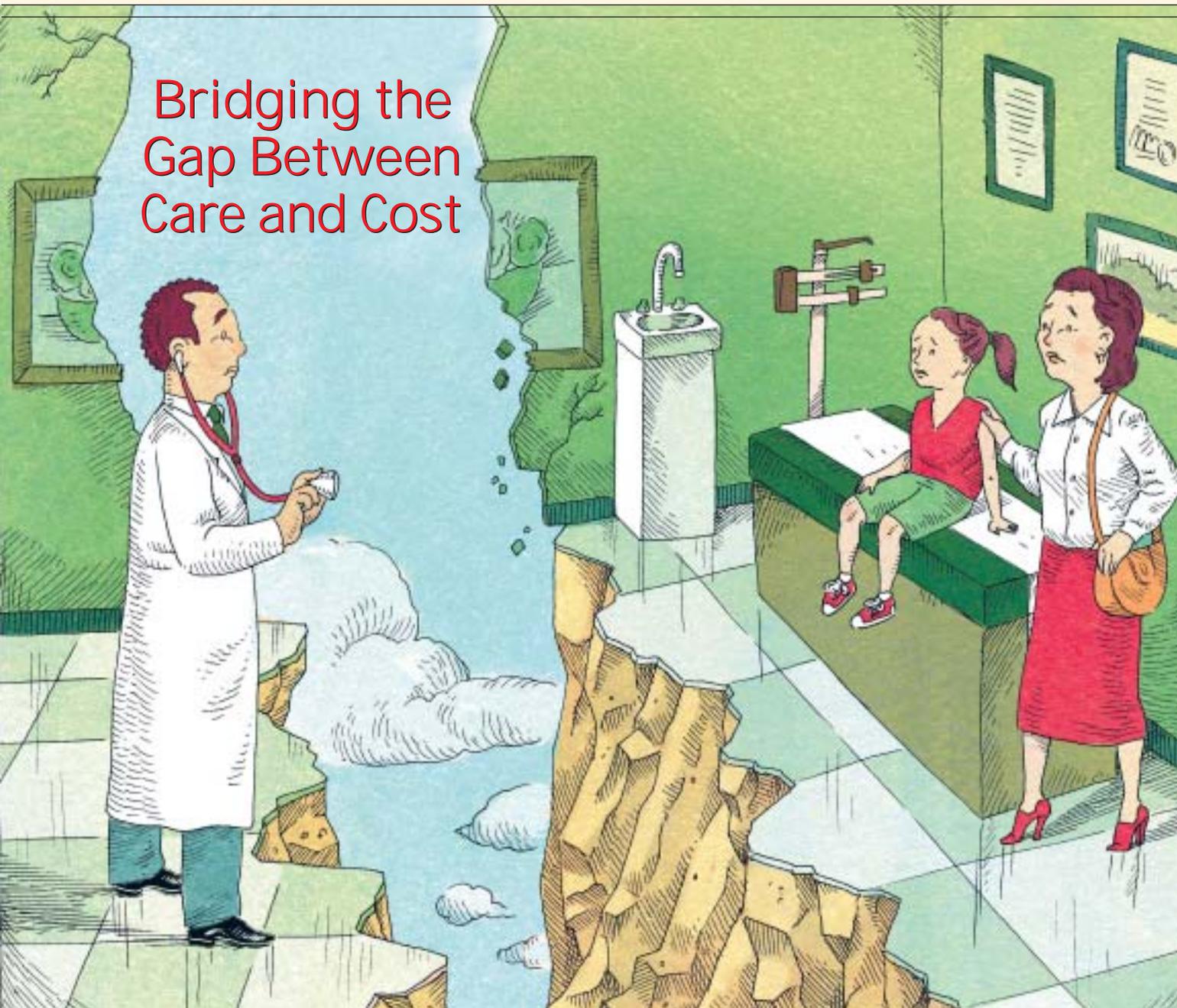


Special Report on Medicaid

Bridging the
Gap Between
Care and Cost



Pew Center on the States Special Report on Medicaid 2006

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States are pivotal players on a wide range of public policy issues and have repeatedly demonstrated their ability and willingness to take innovative approaches to solving important problems faced by the public. Given the impact that state policy makers' decisions have on both individual citizens and the country at large, the stakes in this arena are very high. **The Pew Center on the States**, an operating division of **The Pew Charitable Trusts**, seeks to identify and advance effective public policy approaches to critical issues facing the states by analyzing real-world experience, highlighting examples of what works and what doesn't, calling on diverse perspectives, and collaborating with a wide range of partners and funders.

The report that follows represents the first major accomplishment of the Center, which is overseen by **Susan Urahn**, director of State Policy and Education at the Trusts. The report was designed, managed and edited by **Katherine Barrett** and **Richard Greene**, both senior project coordinators with the Center. Their Trusts-funded report about health care won the National Institute for Health Care Management's Health Care Journalism Award in 2005.

Penelope Lemov, *Governing* magazine's associate editor and health care columnist, was executive editor of the project.

The research/writing team was led by **Rebecca Adams**, a reporter at *Congressional Quarterly* who was chosen for the national Kaiser Family Foundation health journalism fellowship in 2003-2004. **Gary Enos** has contributed to many publications and served as editor of the magazines *Behavioral Healthcare Tomorrow* and *Addiction Professional*. **Jenny Mandel** has written for numerous publications, non-profit groups and international organizations on topics including childhood health and Internet technology. **Misha Segal** has worked on policy issues at the Urban Institute and has been an independent consultant for health insurance and public health associations.

Governing staffers contributing to this report include: design director **Jandos Rothstein**, art director **Bonnie Becker**, production manager **Tonya Namura**, managing editor **Anne Jordan** and editorial assistant **Ben Delman**.

The report was carefully screened by two nationally respected Medicaid experts: **Cindy Mann**, research professor at the Health Policy Institute at Georgetown University and a key Medicaid official during the Clinton administration, and **Vernon Smith**, a consultant with Health Management Associates and a former Medicaid director in Michigan.

Illustrations by Wesley Bedrosian

The Great Debate

The high cost of Medicaid puts it in the eye of a storm.

Medicaid officials celebrated the program's 40th anniversary in July, although the occasion didn't feel much like a birthday party. With the federal government drowning in debt and states just emerging from a service-choking recession, the program is at the center of a national debate over how to cut costs while maintaining the safety net for roughly 58 million Americans, including the disabled, low-income children and their parents, pregnant women and seniors. As Drew Altman, president of the Kaiser Family Foundation, puts it, the Medicaid discussion is "about our beliefs about the role of government and our obligations to one another."

Even though Medicaid growth rates have slowed in the past year or two—the economy has improved and states have taken some steps to control costs—Medicaid spending is now more than 21 percent of total state budgets, threatening to drain resources from other key state responsibilities. Overall, the price tag was \$329 billion last year, of which the federal government paid 57 percent and the states the rest. Spending growth is likely to be 7.7 percent a year over the next decade, according to Congressional Budget Office estimates. "Medicaid," Virginia Governor Mark Warner told the National Governors Association in July, "could actually bankrupt



every state in the country before 2020 unless we can get a handle on it."

That dire prediction will not come to pass. Dramatic changes in some states' Medicaid programs have already taken place, and more are inevitable in the near future. High-level commissions and study groups are pursuing broad-scale reform. At the federal level, Health and Human Services Secretary Michael O. Leavitt hand-picked 15 voting members for a commission charged with submitting a report with ideas for the future of the Medicaid program. It was also asked to carve \$10 billion out of the Medicaid bill over the next five years and met that deadline in September with a recommendation of \$11 billion in savings. It suggested such cost controls as new formulas for prescription drug reimbursement, tiered drug co-payments for

Medicaid recipients and barriers to families who siphon off elderly relatives' assets in order to qualify them for Medicaid-reimbursed long-term care. Several months before, the National Governors Association issued a preliminary report recommending some of the same ideas plus a number of others. The NGA also called for more flexibility for state officials to balance the delivery of quality health care with the need to tame costs.

Despite those efforts, many state lawmakers, Medicaid officials, advocates and recipients remain deeply worried about the future of the nation's largest health care program, particularly because some of the cost-cutting proposals on the table threaten to do more harm than good. But the silver lining here is that a number of states are exploring new ways of doing business, developing better approaches to service delivery, creating a track record of success—and asking the federal government to support their innovations.

The articles that follow look at what is happening in state Medicaid programs in specific areas. They are the result of months of careful study by the Pew Center on the States, a new operating division of The Pew Charitable Trusts. This report affords an opportunity to analyze the real-world experiences of states, highlight examples of what works and what doesn't, and inform a crucial policy debate that will affect the lives of millions of Americans.

The Challenge of Change

Medicaid's relentless growth is its weakness— and its strength.

Medicaid is one of the sick old men of social policy—worrying about how expensive things are getting while complaining about its aches and pains. Forty years of providing health care for the disabled, poor and elderly, and what does it get? Threats to cut billions from its budget and to limit its reach and benefits.

In Medicaid's happier days—a mere six or seven years ago—budget-flush states gave the program a jolt of youthful elixir. They increased income levels for eligibility, cut the red tape that had restrained signups and searched for citizens who were qualified for the program but hadn't applied. What's more, with the State Children's Health Insurance Program, six million uninsured children who weren't eligible for Medicaid were awarded a Medicaid-like package of health care coverage. The uninsured rate among low-income children dropped by a third between 1997 and 2003, despite the onset of a recession in 2001.

Those heady days are no more, in part because health care itself has become so costly. While inflation was in the 1.5 to 3.3 percent range from 2000 to 2003, health care spending went on a wild ride: Prescription drug costs rose 17.1 percent annually and inpatient hospital costs went up 11 percent a year. During the first few years of this decade, the economy slid into a downturn, causing Medicaid caseloads to grow. In the past five years, they have increased by 40 percent, taking on not only people who

lost their jobs and became poor enough to qualify for the program but also employees of large companies that have become increasingly unwilling to pay the high costs of health insurance for many of their workers—a problem that will only grow as the nation continues to turn to a more service-oriented economy.

State revenues have not been able to keep pace with Medicaid's unremitting growth, and the federal government, with fiscal problems of its own, has grown ever more unhappy about footing its open-ended share of the bill. Medicaid's mission, meanwhile, is formidable. It finances not only acute care for low-income families but also long-term care and support for individuals with disabilities. Even more challenging is the demographic future. The number of elderly Americans is growing steadily, increasing demand for expensive services such as nursing home beds, other long-term care facilities or home-based care. Already, about one-third of Medicaid's budget goes to long-term care.

There is pressure from all levels of government to rethink all aspects of the program. The program is not fiscally sustainable, and things are not likely to get better without intervention. The net result is that states and the federal government are now X-raying the Medicaid system. What fills many advocates for Medicaid and for low-income beneficiaries with dismay is that the mechanism

being used for the review may ignore the brain and heart of the program and focus exclusively on the wallet.

Balancing the Books

There is, of course, a profound connection between money and care. When it comes to reimbursing its medical providers, for instance, Medicaid is stingier than either Medicare or commercial insurance. Compensation cuts have become one of the most expedient means for saving dollars.

By low-balling compensation, however, the program ends up reducing the number of providers willing to take care of Medicaid patients. According to the California Health Care Foundation, only about half of California physicians participate in Medi-Cal, and the number is shrinking. A focus group of Medicaid participants with disabilities reported difficulty locating providers willing to accept Medi-Cal, particularly specialists.

The cause and effect between reimbursement rates and access to physicians is clear. For many of the fiscal fixes for Medicaid's problems, the unintended consequences of change may be harder to see.

The nation's health care system is often likened to a balloon: squeeze one part of it and another portion expands. This is true in Medicaid as well. Eliminate dental care for adult patients, for instance, and you may wind up



treating them for malnutrition or reducing their chances of finding a job that might take them off of Medicaid. Reduce the number of asthmatics who receive preventive treatment through Medicaid, and the same people may wind up in emergency rooms for far more expensive care.

Then there's the relationship between Medicaid and private insurance. When an individual who has been cut from Medicaid enters a hospital for an emergency, that person cannot usually pay the bill. But hospitals have to balance their books. As a result, 42 percent of the cost of treating uninsured patients is shifted to

private insurance, according to a 2004 report issued by the Urban Institute. That can and does raise private insurance rates. Partners Health-Care, a major academic health system in Boston, reports that Medicaid cuts in Massachusetts have required it to raise charges to commercial health plans by 4 percent.

There's a vicious cycle here. When health insurance costs increase, private coverage tends to fall, Medicaid absorbs some of those who lose coverage, and the ranks of the uninsured grow. But if insurance picks up only 42 percent of the cost of treating the uninsured, where does the other 58 percent come from?

About a quarter of it is paid by the individuals themselves. Most of the rest comes from the states and the federal government, who pony up money for hospitals that provide a significant amount of charity care.

In the final analysis, as much as cuts in Medicaid may seem like real savings for the states and federal government, the bills for uncompensated health care don't go away. They're paid by average Americans and by a variety of state and federal programs. The illusion of real savings comes because those expenses don't flow through just one program and aren't easily tracked.

Questioning Value

Although evaluations of Medicaid programs are plentiful, there are enormous holes in the kind of analytic information policy makers need to make positive change. Relatively few public dollars are spent on determining which treatments work best and how to encourage their use. Often, Medicaid's practices are driven by what is cheapest or easiest, what is politically acceptable and what has been done before—rather than through a determination of what is most effective.

Even when pilot programs are successful, follow-up on those successes is often short-changed, so good ideas aren't replicated as much as they should be. The federal government has focused relatively little analytic attention on Medicaid, given the size of the program. "Compare the literature and resources going into Medicare versus those going into Medicaid," says Andy Schneider, a former congressional aide who is currently a Medicaid consultant. "There's just not an investment in Medicaid."

Part of the issue is that states don't have the luxury of waiting to see if a fresh idea will work. "You don't do a control group. You don't have a counterfactual," says Alan Weil, executive director of the National Academy of State Health Policy. "You do it because you think it'll work."

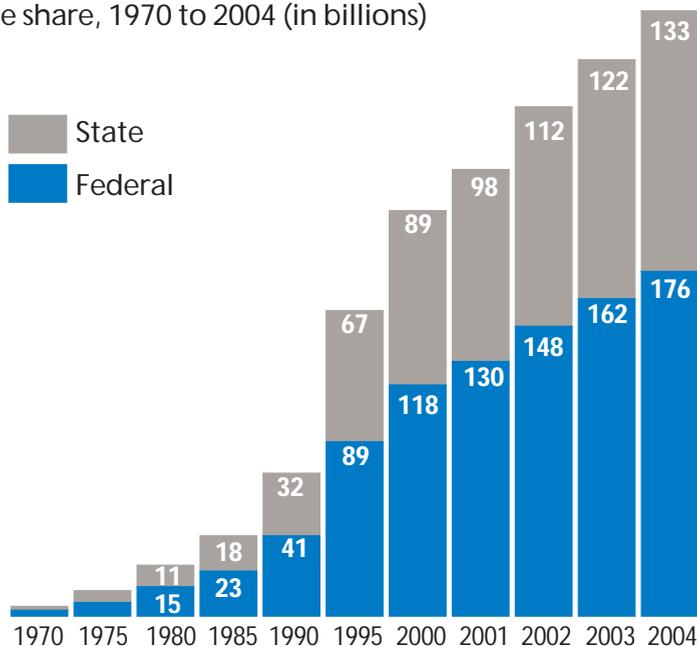
Vernon Smith, a health care consultant with Health Management Associates who was a Medicaid director in Michigan, argues that at the very least, Medicaid programs have an obligation to the taxpayers to get the best possible value for the money spent. It's hard to argue with that logic. But his point is easier understood than accomplished. Consider this: The Centers for Medicare & Medicaid Services (CMS) will pay up to 90 percent of any costs required to streamline or improve claims management. Yet a number of states haven't taken advantage of what would seem to be a golden opportunity. Why? "Even finding just the 10 percent is expensive," says South Carolina Medicaid director Robert Kerr.

An Age-old Problem

So far, states have relied much more on cuts in services for the relatively healthy and young adult beneficiaries rather than the aged or those with disabilities. Politically, it's

The Medicaid Tab

Total Medicaid spending by federal and state share, 1970 to 2004 (in billions)



Sources: Congressional Budget Office and Federal Funds Information for States

easier. It's also an illusion. Senior citizens and people with disabilities make up 25 percent of the Medicaid population but consume 70 percent of the costs.

Clearly, any attempt to constrain Medicaid's growth and spending has to address the elderly and disabled—a tricky task since both groups have strong advocacy networks. "You can't balance your budget for this program on the backs of welfare recipients," Smith says. "There just aren't enough of them, and they are not very expensive people to serve."

A major component of spending for the disabled and elderly has been institutional costs for long-term care. But there is a large group of elderly and disabled patients that lives outside of long-term care institutions, and 40 percent of the spending for this group has been on hospital care—more than half of the individuals were hospitalized within the previous year. Other big expenditures were for home health care, at 24 percent of spending, and prescription drugs, at 18 percent.

Then there is the issue of "dual eligibles"—Medicaid seniors who are also eligible for Medicare. It's an Alice in Wonderland universe. The states, through Medicaid, are re-

sponsible for the bulk of long-term care for older Americans while the feds, through Medicare, provide most of the acute care. Medicare covers all elderly Americans, of course, while Medicaid is generally provided only to those with little or no money.

"If, at age 85, you have the good judgment to pass from this earth in an explosion of acute care services, Medicare will be perfectly willing to pay \$100,000 to a hospital in a non-means tested program, with modest cost sharing," says James Tallon Jr., chair of the Kaiser Commission on Medicaid and the Uninsured. "God forbid that you choose dementia as the route of departure." In that case, Tallon notes, you kick into a national policy that worries about whether you should pay the cost of care out of your reverse mortgage or whether the state can go after your assets or how much cost sharing the state can get out of you. "That doesn't make any sense as a national policy," Tallon says.

Federal Tension

The two programs may not play well together, but neither do the states and their Medicaid partners, the feds. There is an in-

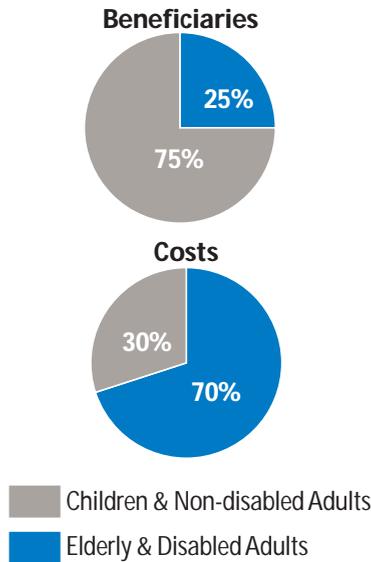
creasing tension between the two. Governors are eager to see Medicare pick up more of the bill for older Americans. At the same time, the federal government is concerned about the ways in which states have amplified their efforts to “maximize federal dollars.” In 2004, for instance, 34 states—up from 10 in 2002—used contingency fee consultants to help increase federal Medicaid reimbursements. According to the Government Accountability Office, Georgia paid a consultant \$82 million between 2000 and 2004 to generate \$1.5 billion in new federal Medicaid dollars.

Some of the efforts to get a federal match for state expenditures are based on logic that aligns with the current nature of state responsibilities. Bruce Vladeck, who ran the Medicaid and Medicare programs from 1993 to 1997, notes that the big growth areas in the Medicaid program in the 1990s “were in services for the mentally ill, the retarded and AIDS patients. Historically, the states did take care of a lot of those problems on their own.”

But many of the efforts have been somewhat less aligned. States are allowed to claim certain health services delivered in schools as Medicaid expenses, for instance. But the accounting required to allocate the appropriate amount of overhead dollars to these legitimately covered areas can be just fuzzy enough to allow some fiscal finagling. In Massachusetts, the Office of the Inspector General for the U.S. Department of Health and Human Services discovered that about \$4.9 million was being unreasonably charged to the feds.

There are also a variety of complicated but legal financing arrangements that states have used to attract additional federal matching dollars. One approach goes like this: States increase payment rates to nursing homes. The federal government reimburses the state for the higher amounts. The states then impose a tax on the nursing homes to recover the cost of the rate increase. The revenue goes into the general fund to be used however the state wants. The federal government has cracked down on this legal loophole, claiming that unchecked schemes like these could cost the federal government \$5.8 billion over five years. But as quickly as one mechanism for

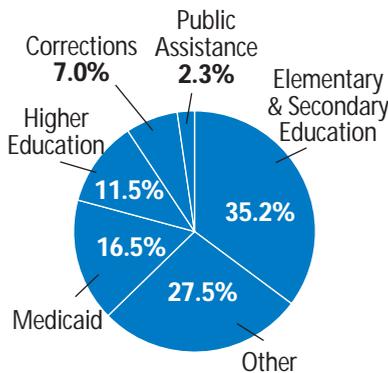
Coverage versus Costs FY 2005



Source: National Association of State Budget Officers

Budgeting Their Own Money

State general fund spending by category, FY 2004



Source: National Association of State Budget Officers

siphoning federal dollars has been squashed, another seems to take its place.

At the same time, the federal government has become steadily less supportive of states' efforts to manage their programs well.

One small way that the federal government could help states would be for it to identify a way to measure the cost efficiency per Medicaid beneficiary for each eligibility class, says Arizona Medicaid director Anthony Rodgers. “If I saw that some states were doing much better than us for the same type of beneficiary, I could go to those states and see what they’re doing.”

Many of the states have been unable or unwilling to take up the slack—or don’t have the administrative resources. “Neither the feds nor the states have invested in running these programs well,” says Schneider.

Perhaps the biggest bone of contention is over waivers—the exemptions from established law that the states need in order to experiment with their Medicaid programs. Waivers can take years to win approval from CMS. But even more to the point, advocates for Medicaid beneficiaries are concerned that waivers may not effectively balance cost savings with the need to retain quality and access. For example, they may include limits on the number of people served, which can result in long waiting lists for valuable services.

Meanwhile, governors complain that for some ideas that have already been tested, there shouldn’t be a requirement to get a waiver from federal rules. For instance, states are still required to get waivers to provide long-term care in home- or community-based settings as an alternative to a nursing home. The rule persists, even though a million people already get their care this way and federal officials say they believe home and community care hold the potential for great success.

There is, of course, little patience in most circles for inefficient bureaucracy. When it happens in, say, a department of motor vehicles, the fallout—citizen rage over long lines or interminable waits—can be felt immediately in the governor’s mansion and legislators’ offices. But at least DMV inefficiencies only cost valuable time. When Medicaid doesn’t work as well as it can—and when fiscal constraints keep care from the needy—people can die. If ever there were a state program crying out for close consideration and remodeling—not just to tame costs but to improve service—this is the one.

—Rebecca Adams

The States at Work—A report on reforms being road-tested in the states

Medicaid's Third Rail

Long-term care is shockingly expensive and politically hot to handle

"This is the biggest of the big issues in Medicaid," says James Tallon. The chairman of the Kaiser Commission on Medicaid and the Uninsured is referring to long-term care and all the issues, both fiscal and medical, that revolve around providing care and protection for the impoverished elderly and chronically disabled.

It's a lopsided problem. Long-term care devours one-third of all Medicaid spending, but it serves fewer than 10 percent of Medicaid beneficiaries. It is expensive—and getting more so. People are living longer, thanks in part to new medications and technologies.

But the older the elderly get, the more likely it is that they will eventually no longer be able to care for themselves or have access to support from family members. One spouse is likely to outlive the other by many years, and children have long since received their own memberships in AARP. Most private health insurance plans, as well as Medicare, may pay for short stays in nursing facilities or access to home health care but only under limited circumstances. For people who require extended long-term care, the staggering costs—an average of \$52,000 a year—can quickly eat through any savings or income. Only when that happens is Medicaid called in to pick up the bill.

The tab is not just for ailing seniors. With more than 3.5 million Americans suffering from disabling chronic conditions, severe mental illness or developmental disabilities that necessitate long-term care, 37 percent of those receiving Medicaid long-term care benefits are under age 65 and account for 43 percent of Medicaid long-term care funding.

Healthy Home

When Medicaid first undertook to cover long-term care in 1967, nursing homes were pretty much the only game in town. That explains in part why these institutions are the only type of long-term care guaranteed by federal statute to Medicaid beneficiaries. But the world has moved on, and the use of home- and community-based care is expanding rapidly. In 2004, Medicaid spent about \$31.7 billion on home- and community-based services, while nursing homes consumed \$45.8 billion that year.

Home- and community-based care has humanitarian advantages, but one big question is whether it saves money. Most of the evidence seems to suggest it can. As Medicaid programs triage the most functional patients into programs offering lower-level supports, they can keep much of the caseload away from expensive institutions.

But as states get better at offering sophisticated services in the new, care-anywhere model, costs—and patient demands—are climbing. In Vermont, the average cost of a community-care slot has increased from half the cost of nursing home care six years ago to 80 percent of that cost now. Joshua Slen, director of the Office of Vermont Health Access, believes the cost increase reflects a steadily rising capacity to handle more complex and costly cases in the community. He admits that looming ahead is the question of what to do when an individual can be cared for in the community but at greater cost than in a nursing home.

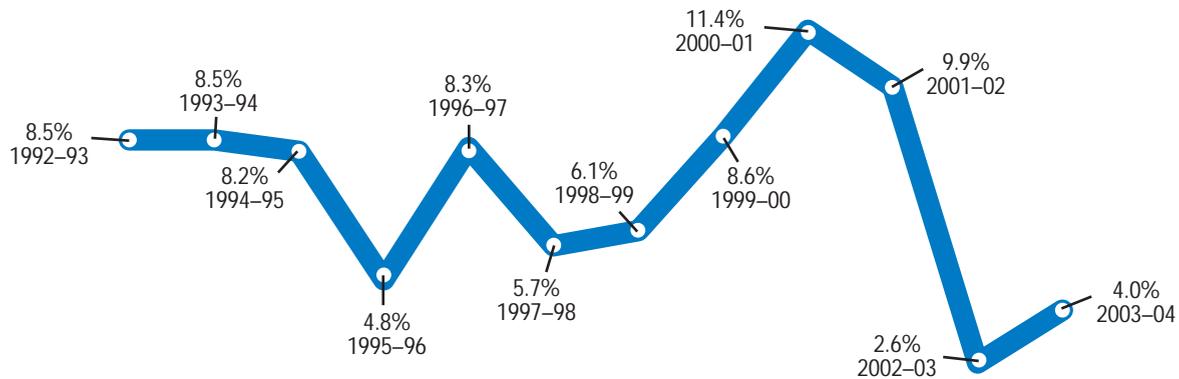
What's more, expenses may be driven up by the so-called "woodwork effect." Many Medicaid beneficiaries need help with daily living—dressing, bathing and the like—but don't apply to Medicaid out of fear that institutionalization is the only option. As a result, there is concern that as home care becomes widely available, these folks will come forward and overwhelm long-term care resources, to say nothing of budgets.

Fortunately, states have ways to control this unaffordable outcome, and as a result it hasn't become as big a problem as some predicted. They use financial eligibility restrictions, waiting lists, functional requirements and measured deployment of services to balance service provision with available funds.

The tricky part is to make sure that people get the service option that is right for them and cost effective as well. Unfortunately, program caps result in waiting lists, and some in-

Growth Center

Annual percentage change in Medicaid expenditures for long-term-care services, 1992–2004



Source: Centers for Medicare & Medicaid Services

dividuals on a list for less expensive services may be forced to accept a place in a nursing home, the more expensive option.

Vermont recently won federal approval for a demonstration program in which the long-term care eligible are divided into three groups. Those who have the highest needs are entitled to either facility- or home-based care. Individuals with high needs or moderate needs are served next with the money that is available. With total Medicaid funds in this project capped, individuals with lesser needs may have to wait, but the state knows that those with the highest needs will be served first in whatever setting is right for them.

In Texas and a number of other states, some individuals who are in nursing homes can bypass waiting lists for home and community services. Since there is an immediate cost saving by returning them to a community setting, they are granted immediate access.

Connecticut, which launched home- and community-based care for the frail elderly in 1987, reports that it took a while, but actual cost savings eventually showed up. By 2000, “we were seeing an impact that we could attribute to the home- and community-based services option, even though we could see an increase in the use of services from those options,” says David Parella, director of the state’s Medical Care Administration.

A Business Proposition

It should come as no surprise that there’s at least one group resisting the move to home- and community-based care: nursing homes

that fear they will inevitably lose business. Based on that assumption, the nursing home industry in many states has hired effective state-level lobbyists to oppose large-scale shifts in funding and policy.

This scenario plays out differently in each state, but in Ohio, legislative protections ensured automatic rate increases for nursing homes. This meant that even when there were fewer Medicaid patients, nursing homes could charge ever-growing amounts to the pro-



gram. There was a change of heart this year, however. With budget shortfalls looming large, the state legislature shifted the reimbursement system toward a less generous model that should result in lower payments.

Other answers are emerging for keeping the supply of nursing home beds at appropriate levels. Alaska, Florida, North Carolina and a number of other states have implemented certificate-of-need requirements before new beds can be added at any institution.

Georgia and other states have implemented acuity-based payment systems whereby Medicaid reimburses institutions at variable rates based on the patient’s condition. “If a nursing home has easy patients, where everyone is walking around and going to singing therapy, they’re going to get less money now,” says Georgia Medicaid director Mark Trail. “If you have people who are bed-ridden or have dementia, you’ll get a higher payment.” The program is cost-neutral in that it shifts payment levels among institutions. Trail estimates that occupancy has gone down statewide by about 5 percent as a result of the payment change.

In some states, Medicaid officials are focused on working with the nursing home industry to adapt to the shifts in demand. New Mexico, for instance, has been getting nursing homes to add adult day care to the mix of services they provide.

Personal Control

One strategy to retain quality and access has received a great deal of attention, although the jury is out on whether it will help cut costs as well. Consumer-directed care gives beneficiaries an allowance based on their level of need. The beneficiaries can then hire whomever they choose—relatives, neighbors, friends—to provide personal care services. They can also use the funds for approved purchases that enhance their ability to live safely at home, such as a wheelchair ramp or even a microwave oven. A demonstration project, tested in Arkansas, Florida and New Jersey, won high

Heading Home

Distribution of Medicaid spending on nursing facilities versus home health & personal care, FY 2004

STATE	NURSING FACILITIES	HOME HEALTH & PERSONAL CARE	STATE	NURSING FACILITIES	HOME HEALTH & PERSONAL CARE	STATE	NURSING FACILITIES	HOME HEALTH & PERSONAL CARE
Ala.	63.6%	29.9%	La.	44.1%	23.9%	Ohio	53.8%	21.9%
Alaska	35.9	58.9	Maine	32.4	54.5	Okla.	45.0	37.2
Ariz.	46.7	36.9	Md.	51.3	34.1	Ore.	25.0	71.2
Ark.	56.0	24.6	Mass.	48.2	43.4	Pa.	65.2	24.4
Calif.	30.4	42.6	Mich.	77.7	20.5	R.I.	53.4	42.5
Colo.	44.3	50.6	Minn.	33.9	57.7	S.C.	44.3	35.0
Conn.	49.0	38.3	Miss.	61.5	14.8	S.D.	53.6	36.8
Del.	55.6	28.3	Mo.	46.2	37.3	Tenn.	61.9	23.7
Fla.	59.0	32.6	Mont.	55.4	38.1	Texas	36.3	45.1
Ga.	56.6	36.6	Neb.	52.9	33.5	Utah	33.4	46.3
Hawaii	61.1	36.4	Nev.	47.5	32.0	Vt.	39.6	60.0
Idaho	38.5	40.8	N.H.	60.3	38.5	Va.	42.1	27.4
Ill.	47.7	26.9	N.J.	47.6	30.7	Wash.	34.7	55.1
Ind.	46.7	24.7	N.M.	29.5	66.7	W.Va.	50.0	38.0
Iowa	42.5	32.4	N.Y.	37.6	43.8	Wis.	46.9	40.1
Kan.	37.3	53.0	N.C.	41.0	41.6	Wyo.	34.2	50.8
Ky.	54.3	31.7	N.D.	56.2	23.9			

Notes: The balance of LTC spending in each state is on mental health facilities and services. Arizona's figures are based on nationwide patterns and do not reflect the actual spending distribution in that state.

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates from Centers for Medicare & Medicaid Services data

participant-satisfaction rates and improved access to quality care. In Arkansas, for instance, the state realized a 29 percent increase in the number of beneficiaries who were very satisfied with their care and a 58 percent drop in beneficiary-reported abuse. As with other long-term-care options, monitoring is required to ensure quality. To enhance its remote oversight, Arkansas is developing a telephone system through which service providers will "clock in" when on the job.

Early feedback on cost factors has been inconclusive. A Mathematica Policy Research study found that in Arkansas the consumer-directed care program cost more than traditional care. The study attributed most of the difference to higher utilization of benefits but found that the gap dropped to statistical insignificance in the program's second year. Meanwhile, 12 other states are developing consumer-directed care programs.

The approach helps resolve another long-term-care issue: shortages of personal care providers. By allowing beneficiaries to pay friends and family for care, the program can capitalize on an otherwise untapped pool of labor.

Another emerging approach for home and community-based services is managed care. Pioneered by Arizona, the strategy creates a strong incentive to take advantage of the cost-saving potential of localized services. With 61 percent of the long-term-care population served at home and in the community, Arizona officials claim low costs per beneficiary. The state also spends only 27 percent of its

Medicaid bill on long-term care, compared with the nationwide average of 32 percent. Florida is developing a comprehensive managed care program that would integrate acute and long-term care for people over 60. And a number of states are expanding managed care for the under-65 disabled population.

The Take Back

When an elderly person qualifies for Medicaid payment for long-term care, he or she presumably has used up all but a few personal assets and is now impoverished. The reality is that there are a number of ways to fake poverty, notably by transferring assets to children or grandchildren. The Medicaid program discourages such asset manipulation by using a three-year "look-back" to review an applicant's financial situation. Efforts are also made to clamp down on banking loopholes that help people shield their money.

But staying ahead of seniors and the attorneys who serve them is no easy task. Medicaid finds itself playing catch-up to a large community committed to hanging on to their savings, even when that means other taxpayers must take up the slack.

The federal Medicaid Commission has proposed ways to tighten or close some of the existing loopholes, such as extending the look-back period. Many state officials would like to see the federal government set new requirements. "At the state level, we get lobbied every time we try to close loopholes," says Arkansas Medicaid director Roy Jeffus. "We can't get anything through." He esti-

mates that about 5 percent of the Medicaid long-term-care population may be taking advantage of the loopholes.

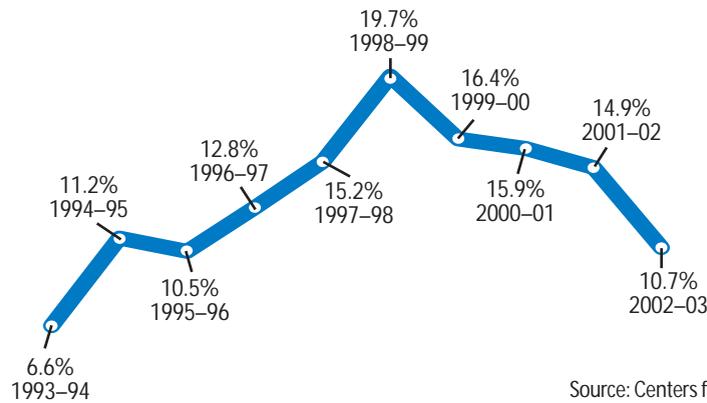
In addition to liquid assets, a number of states are concerned about recovering homes that are exempt from eligibility limits during a beneficiary's lifetime. For them, there is something deeply troubling about a Medicaid beneficiary staying in a nursing home for free for 10 years and then leaving a \$250,000 house to her kids. On the other hand, some have noted the irony of eliminating the inheritance tax for the very wealthy even as inheritance collections get tough at the other end of the spectrum.

In 1993, Congress mandated that states implement estate recovery programs to go after orphaned assets, but many states declined to pursue this tack aggressively. Voter support for snatching the family home away from impoverished elderly—even those no longer using the home—was less than enthusiastic. When the 2001 recession came along and states were in deepening fiscal distress, however, many states had to choose between active estate recovery or deep cuts in services. Some ratcheted up their pursuit of the estates of those permanently ensconced in an institution or deceased.

Georgia began doing estate recovery last year, and the first year of effort has been fruitful, reports Mark Trail. "People are less likely to put grandma in a nursing home if they know the family farm is on the line," he says. The state has seen a drop in nursing home occupancy and a spike in home- and commu-

Pill Bill

Annual percentage change in national spending on prescription drugs, 1993-2003



Source: Centers for Medicare & Medicaid Services

nity-based participation, which Trail believes are linked to the estate recovery effort.

Assets on the Line

Observers of the Medicaid program have long insisted that the free market should be able to buffer some of the costs associated with long-term care, and a focal point has been long-term-care insurance. Many insurance products on the market today are, however, expensive, prone to unexpected premium increases, void if allowed to lapse, inapplicable before the age of 65 and ineffectual at protecting the full extent of a policyholder's assets. In addition, premiums often increase dramatically as individuals age, so people drop their policies just when they need them most.

Still, many observers believe that the quality of the insurance can be improved. If the policies are fairly formulated, they have potential to discourage middle-class and higher-income seniors from spending down assets to qualify for Medicaid.

One federal-state insurance program that has won plaudits is the Partnership for Long-Term Care, a demonstration program initiated in 1988 in California, Connecticut, Indiana and New York. Under this program, individuals purchase a qualifying long-term-care insurance plan, and if they exhaust its benefits, they receive protection of their assets up to the amount payable under the plan, in addition to that provided under normal Medicaid eligibility rules.

In 1993, the U.S. Congress, concerned that the Partnership would shunt benefits dis-

proportionately to the wealthy, passed a law preventing other states from implementing similar programs. But there is support for an extension of the program nationwide, and it comes from the National Governors Association, as well as the 17 states that have passed enabling legislation in case of a congressional reversal. Preventing federal officials "from approving additional partnerships like ours was a mistake," Connecticut's Parella says. "With the baby boom generation coming into that period of time where they're looking at long-term care, they should be encouraged to do everything they can."

Pushing for personal responsibility among the boomers, several states also are supporting tax incentives for long-term-care insurance. Consumer tax credits for insurance

purchases, inclusion of long-term-care insurance under health spending account guidelines and tax credits for employers who pay toward qualifying policies have been put forward as means to encourage middle-class and affluent individuals to purchase this type of coverage. Critics argue that such credits will not heat up the private insurance market enough to justify the tax revenues lost.

While these proposals certainly hold out much hope, in the morbid calculus of long-term care, the same factors that allow so many people to enjoy longer lives translate into increased costs and distressed budgets for families, states and the federal government. Despite the best efforts of so many minds, true long-term solutions are elusive.

—Jenny Mandel

The Rx Factor

States have put the brakes on prescription drug costs, but Medicare may be their undoing.

It was nothing to catch a Medicaid director's eye: In 1990, prescription drugs ran up a Medicaid bill of \$4.4 billion—5 percent of the program's overall expenditures.

Bells were in full alarm by 2003: The tab had climbed to \$26.6 billion—11 percent of expenditures. Medicaid programs in every state began taking cost-cutting measures. And they've had significant success. Prescription drug costs are no longer growing at the

alarming rates experienced between 1997 and 2003. There are no hard statistics to back up the dramatic slowdown—national figures only go up to 2003—but based on interviews with dozens of states, it is clear Medicaid programs across the country have significantly diminished the rate of growth.

In crafting strategies, states found that a critical issue was to keep costs affordable while making sure the benefits of new (and

Although there are risks, preferred drug lists have tamed costs and improved prescribing patterns and quality of care.

often high-priced) medications were still available. Over the past 15 years, more than 300 new drugs, biologics or vaccines have been approved by the U.S. Food and Drug Administration, and many of these new medications are not only life-saving but ultimately cost-effective as well. Since protease inhibitor drugs were launched in the 1990s, for example, the U.S. death rate from HIV/AIDS has dropped by 80 percent. Of course, that remarkable outcome has led to more prescriptions. But treatment costs have gone down. Among Medicaid's HIV patients, there's been a 43 percent drop in inpatient hospital care since protease became widely available. That translates into cost savings of between \$16,000 and \$24,000 a year per patient.

Michael Ditmore, director of the Division of Medical Services in Missouri, shared some statistics that help put the underlying cause for growth in prescription costs in perspective: The number of prescriptions written in Missouri soared by 44 percent between 2001 and 2005, but the cost of prescriptions grew by only 29 percent over the same period. As new medications are developed that genuinely improve quality of life, the name of the game is to keep costs of each medication as low as possible.

Making a List

One powerful cost-saving tool has been the preferred drug list (PDL). The idea is simple. Once a board of experts determines that several drugs in a therapeutic class are equivalent in their effectiveness, states negotiate with

pharmaceutical manufacturers over prices and rebates. The medicine with the best price is added to the preferred list, while the other equivalent products must go through a prior authorization process—the doctor has to ask for approval to prescribe the medication.

California pioneered PDLs in the early 1990s. Drug manufacturers must negotiate on price with the state or risk losing access to its pool of 8.5 million beneficiaries. Similarly, Florida, another big state and early adopter, has enjoyed healthy savings with its PDL: almost \$500 million between 2000 and 2002 for its 2.2 million Medicaid enrollees. Tom Arnold, Florida's deputy secretary of Medicaid, takes advantage of his state's size during discussions with drug manufacturers. "Do you think drug plans are going to pull out of a 2.2 million person market?" he says. "We have the buying power and market power, unlike the commercial marketplace."

Even smaller states have had remarkable success. West Virginia, which implemented its PDL in the middle of 2003, experienced zero growth in pharmacy expenditures in 2004. It helps that the provider compliance rate runs upwards of 95 percent. The state won't be able to sustain zero growth, but it's highly likely that it won't soon hit its prior annual 16 percent rate of growth.

Nearly 40 states now either operate or are in the process of implementing a PDL, but the pharmaceutical industry hasn't gone along willingly. The Oregon legislature was persuaded by a "strong pharmaceutical lobby" to reject a measure to require prior

authorization for drugs not on its PDL, according to Lynn Read of Oregon's medical assistance office. Similar pressure in South Carolina defeated a bill to mandate a PDL for Medicaid, says Robert Kerr, director of the state's Department of Health and Human Services.

Of course, powerful cost-saving tools such as PDLs have risks, too. Some states have been accused of keeping drugs off their lists simply because of their cost—without sufficient regard to their medical benefits. By contrast, even though the Oregon plan may not be the most fiscally effective, it has been hailed by a cross-section of stakeholders for the powerful clinical evaluations it uses before keeping any drug off the list.

In states that have PDLs, Medicaid directors say the lists have not just tamed costs but also provided other benefits. "We've improved the prescribing patterns of the providers, and the quality of care," says Nancy Atkins, West Virginia's Medicaid director. Preferred drug lists have also proved to be an effective way to drive physicians to prescribe generic drugs, which are much less costly than brand-name medications.

The price competitiveness of generics has had other consequences. Manufacturers of brand-name drugs will sometimes offer states a lower price than the generic manufacturers in order to gain access to the PDL.

A Little Togetherness

The strength of preferred drug lists lies in a notion long familiar to any retailer: "The

\$13 million

Savings on prescription drugs Michigan's Medicaid program experienced in 2004 by buying through a multi-state purchasing pool

power of the big pencil." But even states that don't have the enormous buying power of a California or New York can put together a big pencil in a variety of ways.

One is "intra-state" pooling, where a state will negotiate manufacturer discounts and manage the prescription drug benefit for multiple programs, such as the state employee health plan, the Medicaid program and university health plans. Georgia estimates that its intra-state pooling resulted in savings of \$60 million between October 2000 and January 2003.

Several states have looked to interstate efforts. In 2003, Michigan and Vermont created the first multi-state pool, called the National Medicaid Pooling Initiative. Twenty-six manufacturers submitted price proposals. For Vermont, a state with approximately 50,000 fee-for-service Medicaid beneficiaries, the benefits from cooperating with Michigan and its 500,000 fee-for-service enrollees were clear. More than twice the number of manufacturers participated in Vermont's PDL in 2003 than had previously been involved.

In 2004, Alaska, Nevada and New Hampshire signed on. This time, the larger pool generated price discount proposals from 40 manufacturers. According to Paul Reinhart, director of Michigan's Medical Services Administration, his state saved \$13 million in 2004 by purchasing through the pool.

Savings should increase as more states join. In 2005, the pool added four more states—Hawaii, Minnesota, Montana and

Tennessee—and Kentucky has submitted an application to join. Meanwhile, Vermont has left the original pool to form a new one with Iowa, Maine and Utah. Today, the National Medicaid Pooling Initiative represents 3.8 million individuals and wields \$5 billion in purchasing power.

Some health officials worry that further squeezes on the pharmacy tab could be coun-



terproductive. "At this point," says Janet Olszewski, director of the Michigan Department of Community Health, "you would have to worry that any additional changes could harm care."

Tiny Squeezes

One technique, which seemed to be gaining popularity a few years ago, is going out of favor today: limits on the number of prescriptions per beneficiary. This kind of one-size-fits-all approach is seen as a threat to

people's health, even if there are ways to soften the limits in individual cases. "Several years ago, we were looking at a seven-prescription limit," says Michael Deily, director of Utah's Division of Health Care Financing. "But that limit went over with our population like a lead balloon." Today, Utah has taken a different tack. Through a contract with the University of Utah School of Pharmacy, it looks at the people with multiple prescriptions to figure out the reason for such high numbers. "We found multiple prescribers who didn't know the other existed and also found errors," says Deily. "This specific effort is saving the program about \$3.5 million."

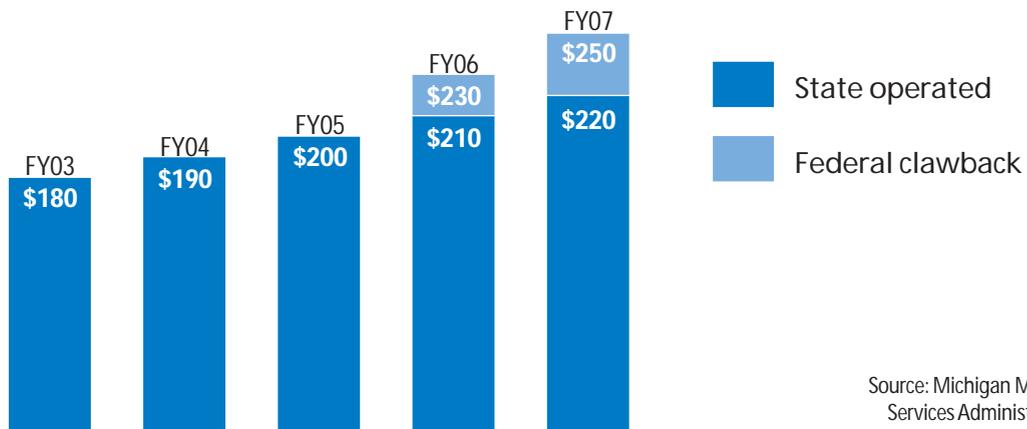
There are several other ideas making the rounds, but they're pretty much untested for the moment. For example, the federal Medicaid Commission suggests basing pharmaceutical prices on Average Manufacturer Price rather than published Average Wholesale Price as is done today. Since the manufacturer price is lower than the wholesale price, the federal Centers for Medicare & Medicaid Services estimates savings from that approach of \$4.3 billion over the next five years.

State Medicaid directors think this number is overly optimistic. In any event, they believe there are real problems with both benchmarks and that changing from one to the other won't help. Many are skeptical about using an average that is based exclusively on drug company calculations.

States are more hopeful about saving money through limits on dispensing-fee payments to

The Giveaway

The impact of federal “clawback” on Michigan’s costs when Medicare takes over prescription drugs for dual eligibles (in millions)



Source: Michigan Medical Services Administration

pharmacies. The amount paid for distributing and dispensing drugs accounts for 23 percent of Medicaid pharmaceutical expenditures. Bypassing the pharmacy altogether offers promise. Maine, for instance, has demonstrated success with its mail order program. The state nets 9 percent every time it moves a prescription to the mail. Of course, there are potential trade-offs here, as pharmacists can educate patients about medications, watch out for unpleasant interactions and monitor compliance.

700 Pounds of Gorilla

Many state officials are not so much concerned with creating new pharmacy savings as they are about retaining the tools that enabled those savings. Starting this year, the dual-eligible population—people entitled to Medicare who are poor enough to qualify for Medicaid as well—will receive their pharmacy benefit from Medicare. Historically, these individuals were covered for pharmacy by Medicaid, and their pills constituted roughly half of Medicaid’s drug bill.

Without the dual eligibles in their bailiwick, states could find they have less leverage when negotiating price with pharmaceutical companies. That will hurt, but it won’t be deadly. “Instead of the 800 pound gorilla we are today,” says Florida’s Arnold, “we’ll be a 700 pound gorilla.”

Loss of leverage is not the only issue states face. They may also lose access to vital data. Under the Medicare Prescription Drug Improvement and Modernization Act of 2003, prescription drug plans under Medicare are

not required to share their data on the dual-eligible population with Medicaid programs. That, in turn, could weaken other important Medicaid programs, such as disease management and care-coordination efforts that rely heavily on such information.

Finally, the Medicare prescription drug bill may actually cost states money outright. A provision in the bill—often referred to as the clawback—requires states to return 90 percent of pharmacy costs to the federal government’s Medicare program to compensate it for assuming the expense of those patients. But that’s 90 percent of a total that was estimated using 2003 figures and the growth rates preva-

lent at that time—rates that were far higher than today’s. So, the real progress in savings that states have made on medications in 2004 and 2005 are being clawed back, based on what states consider to be unrealistically high numbers. Some states estimate that they are going to fare much worse than they would have in a world in which the Medicare legislation never passed. For example, Ohio expects to come up \$57 million short, New Mexico \$18 million and Michigan \$20 million. Some states are considering legal challenges on the grounds that they are being required to pay for a federal Medicare benefit over which they have no control. —Misha Segal

The Great eHealth Hope

Technology could be a painless cost cutter for the future, but who is willing to pay for it today?

An unhappy patient who speaks little English steps into a public health clinic mumbling about dizziness, nausea, diabetes and Medicaid. He shows the intake nurse a handful of different pills and a Medicaid card, then sits for hours in the waiting room while a translator is found. Unfortunately, he doesn’t know what the pills are for, in any language. Numerous tests—some rather expensive—are necessary to fill in his blank record. Most of the results won’t be in for days, and he heads home feeling no better than when he

walked in. Medicaid is billed for the visit.

An alternate scenario: The same man with the same complaints steps into the same clinic with a tiny plastic card, which is used to call up his complete electronic health record. A physician reviews the record on a hand-held device and makes note of diabetes and heart disease. The doctor reviews the six medications the man is taking, noting that they were prescribed by three different specialists. In the examination room, the doctor surmises that the patient’s symptoms are likely caused

Fly Me to the Moon

Making e-medical records a reality

In 2004, President George W. Bush called for electronic medical records to be available for most American within 10 years, and the U.S. Department of Health and Human Services has taken the lead to bring public and private entities to the table and forge consensus on how to move ahead with health information technology. The past year has seen a flood of proposed legislation calling for investment in eHealth initiatives. Several of these legislative approaches call on

government to lead the way with the enormous buying power represented by Medicaid, Medicare, veterans' and other government health plans.

But one question being raised about that effort is the timetable. Why is HHS's time frame for wide-scale implementation—an implementation that would use technology we already have—the same as President John F. Kennedy's was for landing on the moon, using technology nobody had developed yet?

by a bad drug interaction. She checks her diagnosis against an evidence-based practice database, prescribes an alternate medication and alerts the original doctors. Upon entering the recommendations into her hand-held device, the clinic doctor selects “translate,” and shows the man the resulting screen.

The reality of health care technology today is the first scenario. The average teenager plugs into more sophisticated technology to play Duckblasters online than many health care providers use to manage the critical care they provide. “From nearly anywhere in the world, we can withdraw money from our bank accounts, pay bills, apply for a mortgage, book airline tickets and even order groceries online,” says Michael Leavitt, secretary of the U.S. Department of Health and Human Services. “But, more often than not, we can't share an X-ray digitally from one hospital to another, even if they are on opposing street corners.”

The list of forgone advantages of technology is troubling: Simple innovations can streamline care, reduce duplicative tests and procedures, boost doctors' use of evidence-based practices, eliminate transcription and dispensing errors and simplify billing and reimbursement. And what would be good for the health care system would be very, very good for Medicaid.

It's not like the missing technology is the stuff of science fiction. Virtually all of it already exists and is used in various other disciplines. In fact, the Holy Grail—a fully modernized electronic health record (EHR)—could be-

come a reality without any innovative technological advances. Estimates of cost savings vary, but in 2004, then-HHS Secretary Tommy Thompson estimated that nationwide adoption of EHR systems could save 10 percent of the country's annual health spending. With spending at \$1.7 trillion a year, that's \$170 billion annually. For Medicaid, a 10 percent annual savings would amount to a cost reduction of \$33 billion per year. And these savings would likely be accompanied by better medical care, a greater capacity to deal with more home-based care, improved preventive care and wider use of disease management.

With political leaders from President George W. Bush to Senators Bill Frist and Hillary Rodham Clinton calling for EHR, and with the potential of a financial windfall from it, why is it taking so long to get health information technology moving? The simplest answer is sticker shock. A September 2005 study by Rand Corp. places the cost at \$8 billion annually. Another fundamental obstacle is that the American health system consists of so many moving parts that getting all those entities aligned behind a single system is akin to making the dozen apocryphal clocks chime simultaneously.

Federal and state agencies, hospitals, HMOs, private providers, pharmacies and private insurers all have their own mix of technological tools and paper-based systems, developed over years of operation. But this has been a flawed evolution: The technologies can't be used in a uniform, interactive way. What's true of the health care system in general is re-

flected in Medicaid as well. States are riddled with systems that are unable to communicate with one another. Joshua Slen, director of Vermont's Medicaid program, has found that communication among all the interested parties is one of the biggest challenges to moving forward. “We're blessed that Vermont is a small state,” he says. “But IT is complicated even for us where we can get the 100 people who make the decisions in a room together.”

Action Figures

Although a nationwide EHR program lies in the future, individual state Medicaid programs are making some health IT progress right now. For the moment, the federal government provides a match of 75 to 90 percent on most Medicaid IT infrastructure investments and that has allowed many states to improve their existing Medicaid Management Information Systems (MMIS). About half the states are revamping their systems. The state of Washington, for instance, is upgrading its 30-year-old technology, and that raises the question of why it has taken a state that is often ahead of the curve on technology so long to revamp a basic system like MMIS. “Even though it's 90 percent paid for by the federal government, you still have to pony up 10 percent,” says Doug Porter, who works with the Medicaid program. “If it's a \$150 million system, there are probably 10 initiatives where the legislature would rather spend the \$15 million.”

Some states say they are forced into revamping, regardless of cost, because their systems are too out of date to maintain. In Ohio,

*\$33 billion
Estimated amount of money
Medicaid could save annually with a fully
modernized electronic health record.*

Medicaid officials are about to redo their 20-year-old medical records system. It is written in a programming language that is now obsolete, and the state can no longer find programmers to maintain the program.

Some states are spending money on IT innovations in segments of their Medicaid systems. Utah is investing in a statewide electronic immunization registry that allows physicians and health departments to cross-check the same database. Wisconsin has updated its MMIS to be Web-based, with 90 percent of claims submission and real-time adjudication of pharmacy claims online, for a saving in administrative costs of \$90 million over five years.

Des Varady, CEO of Portland, Maine-based Health Watch Technologies, says the first step toward many innovations is simply tidying up systems for data warehousing, third-party billing, utilization review and other aspects of Medicaid management. Some states, he observes, have excellent data, which means they can get electronic services up and running in little time. Others still need to groom and process the data they have—something that could take many months—to get services off the ground.

eScrip Writers

A number of states have been using technology to better manage the use of prescriptions. In Florida, a three-year old program is focusing on this area. Since about 80 percent of state Medicaid prescriptions originate with 20 percent of the physician pool, the state

looked at ways it could help those high-volume doctors manage their prescription records more effectively.

The ensuing program equips high-prescribing doctors with handheld devices that provide them with real-time data on the medication history of each of their patients. The state sent letters to the target physicians inviting them to participate in the program. Those who signed up received a palm device that op-



erates on standard cell-phone networks, with specially designed software to manage prescription records. In the first phase of the program, the device acted as a reference tool, with a patient's identification number calling up a 100-day record of one-time and recurring prescriptions. Armed with this information, physicians could make informed decisions about additional medication.

The results of this phase were heartening. Severe drug interactions dropped from 7 to 4 percent of the 1.7 million beneficiaries cov-

ered by the system, and there was a clear reduction in the number of pharmacy claims and prescriptions. The systems, including the devices and physician training on them, cost \$2,100 per doctor in the first year and \$1,700 each year thereafter.

The program expanded in its second year to provide full e-prescribing. When a doctor enters a new prescription, he receives an immediate confirmation of whether Medicaid covers the medication. The prescription is conveyed to a pharmacy of the patient's choice, eliminating confusion over illegible handwriting or lost paper prescriptions, and the patient can pick up the prescription at his convenience.

The device is simple to operate, works anywhere a cell phone would and eliminates that phase of an exam in which the doctor must figure out a patient's drug regimen from a combination of charts and the patient's sometimes sketchy recall. Also, if the physician sees from a patient's record that drug abuse may be taking place—too many prescriptions for a single medication, for example—the doctor can flag the record for state review. Net savings for two years: about \$50 million.

Digging Deep

Data mining is a hot buzzword in health IT, and the concept is pretty simple: Glean useful information from data already in hand and use it to improve the system.

One potent example comes from Rhode Island. A drug utilization review board was discussing whether balance problems that lead to many elderly people falling and winding up in

States are using technology to better serve pregnant women in rural areas and help prevent seniors from falling—saving money in the process.

hospitals might be caused by the medications they are taking. The state mined its database of Medicaid, Medicare, veterans' and hospital records and found that among those who were 80 years of age or older—40 percent of whom suffer falls that lead to hospitalization—many were taking medications deemed “high risk” for causing dizziness and drowsiness.

From data that were already being collected, the state identified 7,200 patients who were at high risk for falls. In total, they were seeing 1,400 doctors. Letters were sent out to those doctors highlighting the problem and listing the full medication regimens for each of the vulnerable patients in their care.

The letter-writing campaign, backed by the state's hard data, led to an 8.5 percent decrease in the number of people taking four or more medications, for drug savings of about \$350,000. The state has not completed a formal assessment of the campaign's effects on falls and nursing home admissions but expects to see a lower admission rate. That's helpful to Medicaid's bottom line. “Some of the monetary value is immeasurable, too,” says Frank Spinelli, administrator of Rhode Island's Center for Adult Health. “If you're mailing letters about a best practice, other patients will benefit.”

Phoning It In

In Arkansas, one technology focus has been on ensuring that pregnant women who are considered high risk have access to specialized medical care, even if they live in a rural area far from a major hospital.

At the core of the program are telemedicine and video-conferencing, which are put to use by Arkansas's specialized fetal medicine center located in Little Rock. The hospital has a tele-consultation program that “sees” about 50 Medicaid patients per week. In a three-way hook-up, a conference might include a genetic counselor based in Fayetteville, a fetal medicine specialist in Little Rock and the patient and her doctor in a local examining room. The specialists can remotely operate an ultrasound to examine the patient. When the time

comes for delivery, the pregnant woman is transported to Little Rock.

Improved birth outcomes have resulted in \$17 million in savings annually to the Medicaid program. These savings come not only from reductions in the length of newborns' stays in pricey intensive care settings but also from a diminution in the need for home health care, which is usually required by neurologically traumatized newborns, and reductions in subsequent long-term care.

—Jenny Mandel

Something of Value

Will cost sharing make Medicaid patients better health care consumers or sicker ones?

Medicaid has long been wary of asking beneficiaries to share the costs of their care. For most recipients, the program has not permitted premiums or anything beyond very minimal co-payments for a limited number of services. But that's likely to change—and soon. Medicaid officials at both the state and federal levels argue that the free ride is as outmoded in medicine as the house call.

For a model on cost sharing, many are looking at the State Children's Health Insurance Program (SCHIP), which covers young people with somewhat higher family incomes than those who receive traditional Medicaid benefits. There, states have more leeway to impose charges and participants

with incomes above 150 percent of the federal poverty line can be asked to pay a cost-share of up to 5 percent of family income. The preliminary report on Medicaid reform from the National Governors Association (NGA) calls for Medicaid to follow SCHIP and to allow cost sharing but with a 5 percent cap for all beneficiaries, which the NGA considered “a critical balance to this proposal.”

That's not the only cost-sharing suggestion out there. The federal Medicaid Commission would like to give states flexibility to increase co-payments on non-preferred drugs above the current nominal maximum of \$3 per prescription—to encourage “cost-effective utilization.” The Centers for Medicare &

“You have to have some economic tension—people have to have some skin in the game.”

TENNESSEE GOVERNOR PHIL BREDESEN
ON COST SHARING FOR MEDICAID PATIENTS

Medicaid Services estimates that \$2 billion could be saved over the next five years if states were allowed to increase their caps in a variety of ways.

Out in the states, these proposals find sympathetic ears. Many state officials—Medicaid directors among them—deem co-payments, deductibles and premiums entirely appropriate in a time when nearly all Americans are expected to pay something for each physician visit or prescription. They argue that a lack of financial accountability encourages beneficiaries to use medical care when it's not necessary.

“You have to have some economic tension—people have to have some skin in the game,” says Tennessee Governor Phil Bredeesen. He adds that it's not enough to dismiss co-payments on the basis of poverty since most other services ask for some payment by the poor. “At faith-based clinics,” he points out, “they take it as an article of faith that everyone has to pay something for the service—that what you get for free, you don't value.”

Bredeesen's argument appeals to the American ideal of self-sufficiency, and it is a cornerstone of the NGA report. “The purpose of increased cost-sharing is not to restrict access to necessary medical care,” it states, “but to allow individuals to contribute to the costs of their own health care as much as possible. These new policies would be monitored and evaluated heavily, and if the evidence shows that increased cost sharing harms appropriate access, the policies should be revised.”

Check Out the Evidence

Currently, most state officials have difficulty producing hard data to prove claims that this technique will instill personal responsibility in Medicaid beneficiaries and thus save money. In fact, some observers argue that co-payments, deductibles and similar requirements may result in clients' failing to access services or dropping coverage altogether. Preventive care, which can easily be delayed or ignored, may well be the first casualty. This ultimately can endanger the health of medically needy citizens and eventually generate higher costs in the system.

Washington State's governor, Christine Gregoire, is particularly concerned about preventive care and has emphasized the importance of getting coverage for all the eligible children in her state. So, when Washington received federal approval to impose a \$10 monthly premium for families at 150 to 200 percent of poverty, she suspended that particular plan.

One factor that makes the debate over cost sharing so complicated is that the Medicaid population is not homogeneous. According to Chuck Duarte, administrator of the Nevada Division of Health Care Financing and Policy, co-payments and other charges work “for higher-income populations, who are more used to insurance products that use cost sharing. But for the aged and disabled population, with multiple prescriptions and frequent physician services, cost sharing is not going to be an ef-

fective tool. These people already have a hard time paying for whatever they have to pay for to stay alive.”

A few years ago, Vermont imposed premiums on higher-income groups in its Medicaid and SCHIP programs. Forty thousand people were hit with the premiums in December 2003. The following month, 11 percent of those clients were disenrolled for non-payment of premiums. However, just a month later, about one-third of the disenrolled paid their way back into the program. Vermont officials say they generally have seen this pattern when they increase cost-sharing requirements.

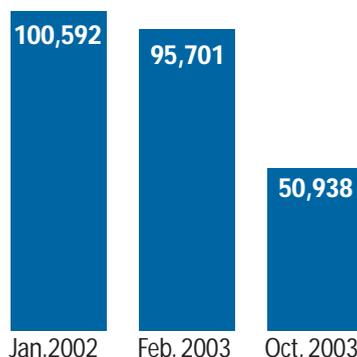
Joshua Slen, director of Medicaid in Vermont, is not alarmed about the drop-off in Medicaid rolls. Slen—and a number of others—believe that those who stay out of Medicaid after premiums are increased are a generally healthier group than those who stay in the program. “If you look at the program,” he says, “it's clear that the people with higher levels of need continue to pay the premium.”

The Oregon Case

Medicaid-eligibles in the entitlement portion of the Oregon Health Plan are not required to pay premiums or co-payments. But a federal waiver in early 2003 allowed the state to tighten up on other Medicaid beneficiaries. This group falls under the Oregon Health Plan Standard (OHP Standard) portion of the Medicaid program where state officials increased the premiums to a range of \$6 to \$20 a month based on income and also

The Fallout Factor

Oregon Health Plan Standard enrollment, before and after premiums and co-payments were added



Source: Kaiser Commission on Medicaid and the Uninsured

tightened rules on nonpayment. They lifted exemptions from the premiums for such “hardship” groups as the homeless and imposed stricter payment deadlines that, if unmet, resulted in an immediate loss of Medicaid eligibility for six months. In addition, many adults covered under OHP Standard were subject to co-payments of \$3 to \$250 for most covered services.

Shortly after these changes were imposed, enrollment in OHP Standard dropped significantly—from 95,000 in February 2003 to just over 50,000 by the end of the year. At the lowest income level, 59 percent of beneficiaries with no incomes lost their Medicaid coverage after being required to pay a \$6 monthly premium.

“While it is difficult to do a cause-and-effect because so many other changes were going on at the time, this was the most salient factor in the decline in program enrollment,” says Lynn Read, acting administrator of the Oregon Office of Medical Assistance Programs. “It’s clear that there were significant hardships as a result of premiums.”

An analysis by the Kaiser Commission on Medicaid and the Uninsured found that 72 percent of those who had been disenrolled from Medicaid had remained uninsured. Only 11 percent returned to OHP, and even fewer found employer-sponsored coverage.

The analysis also noted that physicians in the Portland area reported that patients were “self-selecting not to schedule follow-up visits, and, as a result, their health outcomes are getting progressively worse.” One Medicaid

participant said she raised money for her co-payments by buying small bags of potato chips with food stamps and then selling them for cash in office areas of her community at lunchtime.

Advocates in Oregon sued the state and the federal government over the mandatory premiums and co-payments, saying CMS did not have the authority to waive statutory restrictions on cost sharing. The state government prevailed on the premiums issue but not on co-payments. It has not enforced co-payments under OHP Standard since June 2004.

Some states have since held off on plans to seek waiver approval for stricter cost-sharing requirements, and several state health care officials have expressed their doubts about its effectiveness, particularly for the most financially vulnerable. “There may be some argument for selective co-payments, in areas such as inappropriate ER utilization,” says Mark Moody, administrator of the Wisconsin Division of Health Care Financing. “But seeking ‘flexibility’ in this area is often code for ‘flexibility to cut benefits.’ ”

—Gary Enos

Tools to Live By

Improved management is one way to stretch Medicaid dollars and improve quality of care.

“The old model for Medicaid programs was we were bill payers, but there has been a renewed call for better management,” says Doug Porter, assistant secretary of the Department of Social and Health Services in Washington State. Today, he says, “You start reconsidering what it is you’re buying, why and how you pay for it, and who you buy it for. You shift from paying claims to managing the demand on your program.”

One of the most effective tools for better management of Medicaid has been

managed care. In recent years, a growing number of states have moved many of their Medicaid beneficiaries into such programs. Many pay a per capita fee for the care of each patient (so-called capitated plans), transferring financial risk to the managed-care organization. Providers, at the same time, can be rewarded for providing better care—not just more care.

A report by The Lewin Group, a health care consulting firm, noted that capitated managed care saved Florida 8 to 9 percent compared with fee for service. Similarly, the

Bleeding Dollars

Stanching the flow of misuse and abuse confronts a hard reality.

Florida reimbursed \$11.6 million to providers for services rendered after patients had died. A provider in California was found guilty of billing 32 hours of services on a single day. In New York State, physicians bilked the system by prescribing HIV/AIDS drugs for bodybuilding purposes, school districts were reimbursed for phantom speech services, and ambulance carriers paid beneficiaries to pretend they needed transport.

There is fraud, waste and abuse in the Medicaid program, much of it coming from providers. The issue gained national prominence last year after an exhaustive *New York Times* investigation exposed

rampant overpayments that occurred in New York State.

The most egregious problems tend to be intentional abuses. The more common ones may be simple mistakes. States that have excelled in pursuing overpayments of both kinds have developed a number of tools that make the job easier. In 1999, California created a fraud prevention bureau and added more than 250 staff for the effort. California collects fraud referrals and coordinates with other agencies to audit, investigate and apply sanctions. Total savings after expenses through 2003 were \$80 million.

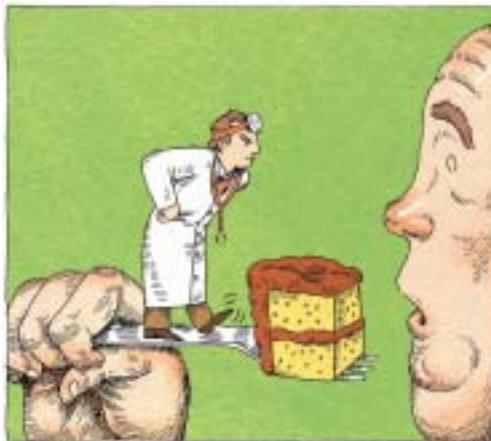
Tennessee set up a special inspector general's office. Illinois does on-site inspections of high-risk providers. It conducts criminal background checks before admitting some providers into the program and has a probation period for the first 180 days of enrollment. South Carolina has improved its recovery rate by upgrading its technology and analytical capabilities and by emphasizing

legislative analyst's office in California estimates in a 2004 report that its managed-care system saves the state "hundreds of millions of dollars annually." No surprise then that many states are now expanding their managed-care programs and including the disabled and elderly.

Success, however, requires maintenance and oversight. Consider Illinois. It has served only 10 percent of its Medicaid beneficiaries that way and not necessarily well. A 2004 U.S. District Court decision about health care access found that Illinois' managed-care companies offered children on Medicaid less in the way of preventive services than fee-for-service systems. A Lewin analysis found that money actually spent on medical services, as opposed to administration or profit, was as low as 49 percent in one managed-care organization, compared with well over 85 percent by managed-care groups in such states as Washington and Pennsylvania. The more successful programs used independent enrollment brokers (to avoid excessive marketing costs), client education, technology to monitor encounter data, skilled individuals to provide oversight and independent evaluation.

One advantage to managed care is that it lends itself more readily to tracking and charting providers through quality measures, and states are increasingly utilizing their capacity to do this. In Virginia, for example, a managed-care performance report records the quality of care and outcomes for patients.

Medicaid managers also have access to an accreditation process through the National Committee for Quality Assurance. The NCQA, in collaboration with *U.S. News & World Report*, has ranked a number of its accredited Medicaid managed-care plans in terms of how thoroughly they cover areas such as breast cancer screening, child im-



munization, flu shots for adults and eye exams for diabetics.

An alternative approach in managed care is primary care case management. This system pays providers to manage the care of an individual, while still permitting the same provider to charge for individual services. The point here is not the payment system so much as establishing case-management services and physician responsibility for a set of patients. Arkansas, for example, has been successful at establishing case-management

programs through physician networks. The system still operates on a fee-for-service basis, but by giving doctors an administrative fee per member each month and offering them administrative extras—such as quick payment and electronic tools—patients end up with a medical home. When Arkansas started this program, "right off the bat our emergency room use started an instant decline," says Roy Jeffus, director of the Arkansas Division for Medical Services.

Damage Control

Many of the principles behind case management stem from disease management, a tool that appears to have great potential. The idea is to supervise the overall care of patients with chronic diseases to prevent health crises and avoid unnecessary hospitalizations. "This is the next generation in improving care by managing it better," says Brendan Krause, a health analyst at

the National Governors Association.

With disease management, a Medicaid program can take utilization data and mine it to identify those who suffer from a particular condition and then communicate with them directly. Individuals who have asthma, for example, can be asked to participate in a program that educates them on the effectiveness of anti-inflammatory drugs. In North Carolina, the asthma program lowered hospital admission rates by 34 percent, and costs per beneficiary by 24 percent.

civil recoveries and the state's False Claims Act, which enables it to collect three times damages in civil cases.

One area of unintentional waste has been third-party coverage. Private insurance, the Veterans Health Administration or Medicare can sometimes be responsible for charges that have been paid by Medicaid. By pursuing such claims, Maine's Third Party Liability Unit recovered \$17.7 million from third-party payers.

In many states, efforts to eliminate improper payments are not a priority, and resources are not the only issue. One particularly pernicious problem is the very real threat that when a state cracks down too aggressively, providers—many of whom are underpaid anyhow—will quit the Medicaid program. Ohio's Inspector General found that seven speech and hearing centers had overcharged the program \$3.4 million. The state settled for \$155,000 from two of the seven and prosecuted one.

Ohio's surveillance and utilization review chief, Jeff Corzine, said that vigorously pursuing the providers "essentially would have wiped out almost every speech and hearing center in the state, and we would have then lost a service for our population." Since the providers had exploited a loophole in the Medicaid billing cycle, the Medicaid office chose to educate the speech and therapy centers, letting most providers off with a warning.

Collin Wong-Martinusen, the director of California's Bureau of Medi-Cal Fraud and Elder Abuse, points out that unnecessary losses to Medicaid directly contribute to the real reason many Medicaid programs are unable to attract skilled health care providers: Reimbursement rates are woefully inadequate. The aggressive combating of Medicaid overpayments, he says, "will indubitably allow states to retain the level of resources necessary to build and sustain a vibrant provider network." —Misha Segal

At least half of the states have started at least one disease management program. Most have not yet seen significant savings but believe they will in the long term—an optimism borne out by the experience of commercial managed-care plans. In those plans in 12 states, the overall costs per diabetic patient fell by nearly 25 percent. Some of those savings came from a 30 percent decrease in admissions to the hospital.

But the upfront costs are a big barrier for many states. State legislators are focused on the current budget cycle. "Many of the things we're promoting take time to see results," says Melanie Bella, a vice president with the Center for Health Care Strategies and former Medicaid director in Indiana. "There's pressure to show savings within timeframes that aren't realistic."

One reason some states have hesitated to utilize disease management was a disappointing experience in Florida. But Florida's effort, which got underway in 2001, was unique. It relied on contracts with large drug companies to provide disease management services for patients with serious conditions. Under the contracts, state payments were based on actual cost savings. A May 2004 report by the state's Office of Program Policy Analysis and Government Accountability found that the cost savings were overstated and that the Medicaid agency hadn't adequately assessed the health outcomes of the patients to see whether there was improvement. The state legislature ended the experiment with private drug companies. "One of

the lessons learned is maybe it's more appropriate to do disease management in conjunction with managed care—rather than one

disease, one eligibility group at time," says state Medicaid director Tom Arnold.

—Rebecca Adams and Misha Segal

Trading Places

Moving the working poor out of Medicaid and into private health coverage is a slow go.

Few proposed solutions to the Medicaid conundrum seem more intuitively simple than shifting beneficiaries—notably those who hold down jobs—to employer-sponsored insurance. For the mere price of a premium, the responsibility for a whole family could be lifted from Medicaid's shoulders. Even employees of companies with skimpy benefits can be assured of reasonable benefits if Medicaid provides wrap-around coverage. But this is not as easy as it appears.

For starters, private-sector options are shrinking. The percentage of workers under age 65 covered under employer-based insurance dropped from 69 to 60 percent between 2000 and 2005.

Obviously, many workers who don't get employer-based insurance are low-wage earners, and the lower their income, the less likely they are to be covered. In addition, many private plans include cost-sharing provisions that are simply unaffordable. There is also an opposing tide emerging: Employers in service industries are, in effect, encouraging employees whose families are eligible for Med-

icaid to sign up for the public program.

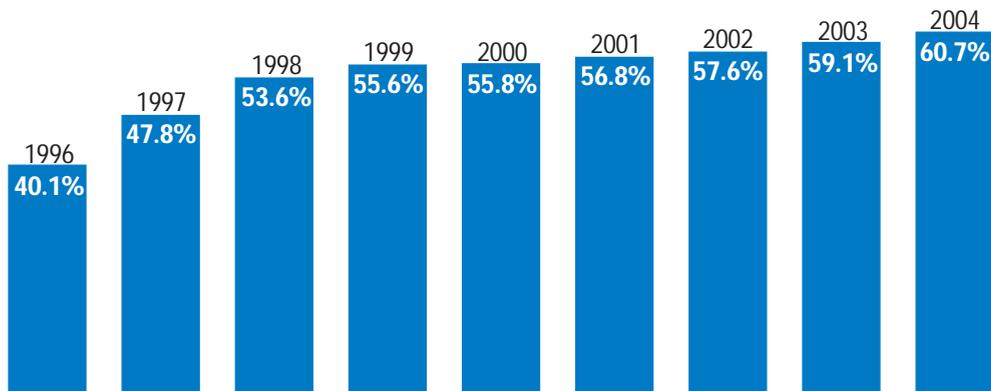
Still, the combination of a politically popular push for self-sufficiency among Americans and the potential savings available when private-sector insurance provides coverage makes states eager to cut through the thorny thicket of obstacles. Many of the experiments they are trying involve subsidizing the private sector with premium assistance.

Joan C. Alker of Georgetown University's Health Policy Institute has closely studied states' efforts in this area and has discovered that many states provide a set level of assistance for any kind of insurance coverage—even if it's inferior to that offered by Medicaid.

Illinois, for example, offers premium assistance of up to \$75 per child per month in the KidCare Rebate portion of its KidCare State Children's Health Insurance Program (SCHIP). Private insurance for these children is required to cover physician and family hospital services, but the insurance can fall short of SCHIP coverage. States such as Illinois and Utah have argued that they guarantee the cost-effectiveness of their premium assistance

Medicaid Management

Percentage of total Medicaid population enrolled in managed care, 1996–2004



Source: Centers for Medicare & Medicaid Services

programs by capping subsidies and requiring enrollees to bear the rest of the costs.

Alker found that these states risk trading off controlled costs for limited use. She found, for instance, an enrollment in Utah of fewer than 80 people. “They’re not moving enough people over, so they’re not making up for their administrative costs,” she says. Of greater concern, she adds, is that some states are not even analyzing the financial impact of their programs.

Alker found that some states, such as Rhode Island and New Jersey, offer more generous subsidies (including wrap-around insurance that guarantees coverage at least as good as that in Medicaid). Those states have been able to drive enrollment up and demonstrate cost savings to boot.

Oregon provides premium assistance for more than 10,000 citizens. It pays up to 95 percent of employee costs for workers, based on income. The coverage must meet a set of requirements that is actuarially equivalent to the federal Medicaid benefit. Lynn Read, acting administrator of the Oregon Office of Medical Assistance Programs, says that employer incentives could yield even better results.

Right Sizing

Although premium-assistance programs are still in the early stages in many states, Rhode Island seems to have jumped ahead of the pack. Anyone in the state’s RItE Care Medicaid program who can be covered in a more cost-effective way by employer insurance must enroll in that plan. To date, 6,000 Medicaid and SCHIP beneficiaries

have done so. That’s about 500 more people than are enrolled in Illinois’ program, although Illinois has 11 times the number of SCHIP beneficiaries.

The effort—dubbed RItE Share—grew out of a 1998 program in conjunction with welfare reform. State officials wanted to make sure that adults moving from cash assistance into jobs had health coverage.

But the state underestimated the cost of success. Not only did the welfare-to-work population migrate to RItE Care, an aggressive outreach effort resulted in many uninsured families enrolling for the first time. This, coupled with a major private insurer leaving the state, caused unexpected budget problems, with the state having to find \$50 million in the first year to make up for its inaccurate enrollment projection.

“We had to do something to stabilize the growth, but we didn’t want to cut back on benefits,” says Tricia Leddy, an administrator of RItE Care Medicaid. So in 2000, the state established the RItE Share premium-assistance program. The state subsidizes employees’ costs based on their income and offers wrap-around coverage to fill any gaps between Medicaid/SCHIP coverage and the employer-based insurance. Individuals carry two insurance cards: their primary employer insurance card and their secondary coverage Medicaid card, which can cover co-payments at the doctor’s office or pharmacy.

State officials have carefully analyzed costs associated with RItE Share, comparing them with Medicaid managed care. “We es-

timate that for every 1,000 enrollees in RItE Share, we achieve \$1 million in savings,” Leddy says.

States that want to emulate Rhode Island should beware of one landmine: The program will inevitably increase administrative costs. The churning effect from people moving in and out of the program is quadrupled in premium assistance, and states must keep track of varying insurance-plan limits, employees’ changing job status and instances when employers are acquired by another entity.

A Unique Approach

In 2003, Arizona developed a state-sponsored insurance program open to businesses with 50 or fewer employees, government agencies and the self-employed. It offers a cafeteria plan of benefit structures and pricing, and the coverage can be funded either by employers or employees.

About 16,000 people are covered under this plan, and the state breaks even on it. So what’s the benefit? “About 12 percent of our beneficiaries would qualify for our Medicaid program if they applied,” says Anthony Rodgers, director of the state’s health care cost-containment system. “We see this as cost avoidance. At the current level, we’re saving around \$5 million in the state portion of general Medicaid funds each year.”

Despite its potential promise, Rodgers does not see state-sponsored plans gaining traction elsewhere. Many are fearful of going into competition against powerful traditional insurance companies. —Gary Enos

The Radical Reformers

Moving forward with an untested approach.

Many of the ideas for controlling Medicaid costs are aimed at saving significant sums of money without changing the fundamental nature of the program. One concept is different. It upends the bedrock principle that low-income patients have an open-ended entitlement to a broad range of hospital, outpatient and other medical services when they need them. Both Florida and South Carolina are planning to cap the coverage provided their Medicaid beneficiaries.

Florida is in the lead, with a waiver approved in October by the federal Centers for Medicare & Medicaid Services. The plan sets aside a specific amount of money for Medicaid beneficiaries and requires that they use their allotment—in effect, a voucher—to buy health-care coverage from private insurers. People who are sicker will be entitled to higher-value vouchers to allow them to buy more care. While some children and pregnant women will still receive the whole range of benefits mandated under existing Medicaid law, most adults and many of the disabled will not.

“What we’re trying to do,” says Tom Arnold, Florida’s deputy secretary for Medicaid, “is bring some certainty to the process.”

The Florida program, which will rely heavily on managed care, is expected to be implemented as a pilot project this year in Broward and Duval counties, affecting 200,000 of the state’s 2.2 million Medicaid beneficiaries.

Officials in Florida and in South Carolina, which has a similar proposal in the works, argue that one advantage of the program is its simplicity: It cuts down on red tape and gives private plans more leeway in designing benefits.



They also see potential for cost savings. Officials believe that the marketplace will force insurers to compete with each other, offering ever-better benefits at lower prices. In addition, the private sector could help slow Medicaid’s growth as private plans—specifically managed-care plans—find more ways to save money.

The potential payoff of a better bottom line, says Robert Kerr, director of South Carolina’s health and human services department, is worth the gamble for both insurers and the states. “If managed care saves money, the plans keep most of that. So what do we get out of it? We get no growth.”

Causes for Concern

Critics have a laundry list of worries about the plans. For Joan Alker, senior researcher at the Georgetown University Center for Children and Families, the proposals are “based on largely untested concepts which will result in the state’s most vulnerable residents

being asked to pay more and receive less for their health care.” Capping the amount of money that the state spends per person does not mean that the health needs of vulnerable families go away. Rather, “their needs will go unmet, which will result in a sicker population, growing levels of uncompensated care, and cost-shifts to private payers.”

Officials in Florida and South Carolina say beneficiaries will not be harmed by limits on their allotments because those allotments will be based on historical claims data for people with their conditions. State officials also say Medicaid will step back in with more funding for catastrophic care if a beneficiary’s health requires care beyond the allotment in any given year.

The reliance on insurance companies to pick up slack worries some observers who point out that insurers have a duty to look out for their own bottom line as well as an individual patient’s well-being.

There are other key concerns:

- Handing each patient a predetermined subsidy based on health status is risky, since quality of health is not very easy to predict.
- Managed care plans and other networks may not want to participate.
- Medicaid recipients—particularly those with limited education—may be overwhelmed when it comes to picking a plan that best covers their needs.

Only time will tell how successful Florida’s pilot efforts will be. One thing is sure: The rest of the states will be watching closely.

—Rebecca Adams

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